danger to our patients and our state, we believe that remaining silent is not an option.

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The Affordable Care Act, 1 Year Later

Michael D. Stillman, M.D.

This past year in Kentucky has been extraordinary. Our freshman-heavy men's basketball team nearly won a national championship, our attorney general refused to defend a decade-old ban on same-sex marriage, and our commonwealth's citizens — among the poorest and most underserved in the country — finally gained broad access to health insurance. While the first two events ignited segments of our populace, the third fundamentally altered our medical practice, allowing us to provide data-driven and thorough care without first considering our patients' ability to pay.

Last year, I encountered a patient with widely metastatic colon cancer whose diagnosis had been delayed because of lack of health insurance.[1] He had clearly become ill at the wrong moment in our commonwealth's history. Before Kentucky Governor Steve Beshear decided to implement the Affordable Care Act (ACA) and accept federal funding for Medicaid expansion, the 60% of my clinic patients and 650,000 Kentuckians who lacked health insurance received disjointed and disastrous care. They could be seen in subsidized facilities and be charged for their visits on a sliding scale, but they were asked to pay in advance for most diagnostic tests and consultations. Many of them avoided routine and preventive care — and worried that a medical emergency would leave them bankrupt.

But during the past year, many of my lowest-income patients have, for the first time as adults, been able to seek nonurgent medical attention. I recently evaluated a 54-year-old man with hyperlipidemia and a systolic blood pressure of 190 mm Hg whose last physician visit had been with a pediatrician. Before he enrolled in Medicaid, he would have been unable to pay for his appointment and laboratory work, and I wouldn't have considered offering him a screening colonoscopy since he would surely have been billed for it. Newly insured, however, he was able to afford the tests and medications that most Americans would expect to receive, and he told me he felt proud to have witnessed a sea change in health care delivery in Kentucky and that recent reforms seemed "just."

Expanded health care coverage has also improved residency education in Kentucky — a benefit that few of us anticipated. Before the ACA, many of our poorer patients declined preventive measures, had limited access to first-line medications, and avoided hospitalization for fear of financial ruin. The residents I taught were hamstrung in their efforts to care for the uninsured and were forced, against their better judgment, to offer and become accustomed to offering substandard and incomplete care. A graduating resident recently reminded me of two patients we had seen during her intern year who ought to have been admitted to our cardiac service for monitoring of unstable arrhythmias yet who, dreading the onslaught of medical debt, had opted for riskier but less expensive outpatient treatment.

One year after the law's implementation, residents at my hospital can finally provide guideline- and evidence-based care. Since 92% of our clinic patients are now insured, we no longer receive fretful looks when we recommend laboratory tests, we screen for colorectal cancer with colonoscopies rather than with less

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sensitive fecal-blood cards, and we spend more time examining patients and less time helping them knit together limited public-assistance resources. This year's intern class can scarcely imagine the difficulties their senior residents encountered when they first staffed our safety-net clinic; that particular ignorance is one we ought to celebrate.

A third benefit of expanded access to health insurance has been an increase in competition for patients. Before the ACA, people lacking insurance were cared for in a limited number of facilities and health centers, and few physicians would have welcomed them into their practices. With increased enrollment in Medicaid and commercial plans, these same patients are pursued by medical groups and hospitals and can be selective in choosing their sites of care. Although patient choice may or may not improve the quality of care, it has prompted me to be more attentive in my own work, and I now frequently remind my residents that a frustrated or dissatisfied patient may never return to our clinic.

Although the ACA rollout in Kentucky has been a success — with 413,000 people gaining coverage[2] — the law continues to face considerable challenges. Some Kentuckians question the adequacy of the newly purchased plans and are concerned that despite being "insured," people who have bought low-premium, high-deductible plans may wind up accruing substantial medical debt. There is certainly need for policymakers and insurers to ensure that purchased benefits are both adequate and fair. In addition, the governments of 23 states have yet to expand Medicaid eligibility, and many of those states, particularly in the South, have higher-than-average rates of poverty and chronic disease.[3]

Physicians can do a great deal to help improve the lot of the medically underserved. First, we can challenge our elected officials to do a better job of seeing to their constituents' needs. It is unfathomable to me that Kentucky's two senators, who are well aware of the ACA's beneficial effects in our commonwealth, continue to oppose the law and that geography can determine the adequacy of Americans' care. Furthermore, we can delineate for our patients the often-subtle links between current affairs and their own health. I was once uncomfortable discussing politics with my patients, but now I routinely ask them if they are registered to vote and remind them that certain candidates do not support the legislation from which they have so palpably benefitted. Finally, as our country moves closer to universal coverage, stewardship of limited health care budgets will be increasingly important, and we can consider more carefully the cost-effectiveness and efficacy of our interventions. Physicians have always addressed individual patients' needs, but a new emphasis on public and population health may help broaden our focus to include our country's well-being.

Americans have been offered a plan for near-universal health coverage, and my experience in a resource-poor southern state suggests that there's reason for optimism. I hope that an increasing number of state legislatures will help their vulnerable citizens receive the services they need and that the next generation of physicians will be shocked that our current efforts at health care inclusion were ever seriously questioned.

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